Experiences with the Medical and Health Systems for Somali Refugees Living in Hamilton

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Little is known about the health practices of refugee groups in New Zealand so the present research aimed to provide an overview of the reported health status and the barriers to health service utilisation of Somali refugees in Hamilton. A bilingual Somali interviewed 29 females and 25 males ranging in age from 18 to 63 years. The Somali community reported themselves as being in good health with not much concern. Participants reported that they rely on General Practitioners (GPs) to confide in about their health, to obtain health information, to deal with "mental health" problems, as well as to act as family doctors. GPs were generally judged positively and were seen as caring and friendly with expertise. While overall positive towards medical services, the Somali refugees had many problems accessing the services required, the biggest problem being language, and to a lesser extent transportation and medical costs. Language is an important consideration for health psychology interventions, since compromised language impacts on the ability to access medical services, puts demands on translator services, and wastes public health messages. Interventions to improve the women's English are especially important since the women speak less well but take both themselves and their children to the medical services. The heavy reliance on GPs could put a strain on public health resources and training specialised public nurses or Somali nurses could help this as well as employment for Somali.

Since the Second World War, New Zealand has given sanctuary to over 25,000 refugees of many nationalities who were fleeing wars or civil disasters. Refugees from Somalia have been arriving in New Zealand since 1991, at about 150 people per year. Refugees can come to New Zealand through the quota programme, as asylum-seekers, or through family reunification. The quota programme currently is set to accept 750 refugees per year with specific acceptance of a certain number of women-at-risk, protection cases, and persons with disabilities. More than two-thirds of the world's refugees are women and children and New Zealand specifically accepts many women and children at risk. The Somali community makes up the largest community of current refugees in Hamilton, with approximately 800-900 persons. They have particular difficulties adapting to their new country because they differ on almost every social dimension: religion, colour, race, language, and cultural practices such as dress. As a specific population, only a little is known about their mental and physical health; with a few exceptions, they are a hidden group in New Zealand health research.

There are common and well-known health-related problems faced by refugees that apply even when settling into a developed country such as New Zealand. While there are physical and mental health issues resulting from their previous experiences in war and camps, other health-related problems in New Zealand arise from unemployment and housing, separation from family, poor proficiency in English, changes in food and diet, and changes in daily exercise patterns (Altinkaya & Omundsen, 1999; Blakely, 1996; Guerin, Diiriye, Corrigan & Guerin, in press; Knipscheer, de Jong, Kleber, & Lemprey, 2000). These include mental health issues, anaemia, gastro-intestinal disorders, obesity, back problems, possible diabetes, respiratory problems, dental problems, eye conditions, and vitamin deficiency disorders.

Such physical and mental health problems are exacerbated by problems in accessing medical services (Adair, Nwaneri, & Barnes, 1999; Cheung & Spears, 1995; Keleher & Manderson, 2000). These problems are relevant to psychology and the social sciences rather than medicine alone, since the difficulties stem from interconnected issues of language proficiency, transportation, different views of

health, lack of childcare if the family is not reunited, and a lack of suitably written health information. The reliance on translators for all interactions with medical personnel also reflects the complexity of the issues (Davidson, 2000; Matthews, Johnson, Noble, & Klinken, 2000). Similar problems to those of physical health arise for mental health: utilization and information about services is weak (Cheung & Spears, 1995; Hauff & Vaglum, 1997), and differing conceptions of "mental" health can make it difficult for health professionals to use their expertise even if they are accessed (Bertoud & Nazroo, 1997; Bracken, Giller, & Summerfield, 1997; Mulatu, 1999).

The aim of this study was to provide an overview of the reported health status and barriers to health service utilisation of Somali refugees in Hamilton. We focused on how they conceive good and bad health, what they like or do not like about medical personnel, and problems they have utilising health services. The data gathered were aimed at providing groundwork for more intensive studies of the particular health problems faced by Somali and other refugees in New Zealand. While a few isolated studies have collected health data for refugee groups in New Zealand (Blakely, 1996; Cheung & Spears, 1995; Guerin, Diiriye, Corrigan & Guerin, in press), there is a dearth of information on both health service utilization by refugees in general and the health of Somali communities in New Zealand. This research is a start to address both these gaps.

Methods

Participants

There were 54 participants interviewed, 29 females and 25 males from different households, ranging in age from 18 to 63 years, with an average age of 34.6 years and a fairly flat distribution across the range. Most participants indicated that the family relied on Government benefits, although a few had employment. The participants had been in New Zealand for an average of 37.9 months, ranging from 3 months to 84 months (7 years). Participants were contacted informally through the Somali community networks. Details are not available on the demographic characteristics of those who were not interviewed, but about half of all Somali families in Hamilton had one member interviewed suggesting that reasonable generalisations can be made to the Hamilton population, although there may have been Somali not closely involved in the community who were missed. Further research is needed to clarify this. Figures are difficult to judge since the Government Census only reported about half the (informally well-known) number of Somali in Hamilton and no better data source exists at present.

Of the 54 participants, 14 indicated that they had tertiary level qualifications (mostly not recognized in New Zealand), 24 secondary, 2 primary, and 12 had no formal education. There were a few questions relating to English proficiency that are commonly used, including English proficiency rated on a scale of 0 to 3 (0 = no English and 3 = very good English), and a judgment of how well they could read signs and symbols around the environment-signs such as those at bus stops and medical service foyers. For the English proficiency scores of 0 to 3, there were 11, 14, 13, and 16 participants, respectively, with a little over half of them able to speak some English, and about one third able to speak good English. Participants were slightly more proficient at reading signs and symbols. English proficiency was strongly correlated with gender and age, with males speaking better English than females and younger people speaking better English than older people.

Interview Procedures

The method of interviewing was to "talk around" the topics rather than ask sequentially fixed questions. This follows recommendations by Pe-Pua (1989) for Filipino research, based on Pagtatanung-tanong or "asking around". The method is such that questions are asked in a natural conversational context so participants do not feel they are being interrogated. The information sheet was translated into Somali but because many do not read the language (it was only put into written form in 1972), the interviewer also talked through the sheets with them. Similarly, the questions were written in English but were talked through in both Somali and English depending upon the language preference of the participants. The interviewer (also the 2nd author) was a male, fluent bilingual who frequently acted as translator for the community. For this reason, even though women were offered a female interviewer if they wished, none accepted because of their familiarity with this person translating for them in other contexts.

Interviews were conducted by the interviewer writing notes on a printed questionnaire since participants in general preferred not to use tape-recorders. The interviews were conducted in a mixture of Somali and English in most cases, with the interviewer writing responses in English but checking with the interviewees if the concepts were in doubt. The conversational style of the interviews meant that few, if any, conceptually complex terms were used.

Interview Questions and Topics

The conversations included some simple rating scales (talked through rather than ticked) and open-ended questions, taken from previous health literature or from knowledge of the factors likely to be relevant to refugee health given in the second paragraph. For the rating scales, participants were asked to rate how concerned they were about their health (7-point scale from very unconcerned to very concerned), how they judged their health in relation to someone of their age (7-point scale from poor to excellent), how likely they would seek advice about health from a family member or a good friend (both 7-point scales from not at all likely to very likely), and how often they would talk about health problems to a family member or a friend (both 7-point scales from not at all to frequently). Participants were also asked how often they went out of the house for shopping or work, and whether cost was a factor in not seeking medical care.

For the final rating questions, based on previous literature (Adair et al., 1999), participants were asked on a three-point scale (not a problem, a problem, a large problem) how much of a problem each of 19 barriers or constraints was to seeking and following medical care. The 19 barriers

or constraints included: payment for medical care, doctor understanding them, availability of interpreters, satisfaction with communication, them understanding the doctor, obtaining medical care at multiple clinics, long time waiting to see doctor, transportation to clinic, getting health information, how are the staff in understanding you, getting child care while you are at doctors, location of doctors and emergency, deciding where to go, getting medicines, comfort with being examined, getting an appointment, following doctor's orders, getting help for when you are at the doctors, how are the staff in helping out.

It should be noted that the rating questions were talked through as issues and then a joint judgment for the number made by the interviewer and interviewee. These questions were not aimed at tapping absolutely accurate scores but merely to give an indication of positioning along a scale. In most cases we do not have any baselines to judge the scores relative to a population anyway. In a few cases statistical analyses will be made where there is an interest in following up what seems to be a trend. Further research is necessary to really establish what these differences mean and we hope to do this at a later stage.

The interviewer asked questions in conversational style using prompts to encourage conversation that related to health and medical care, and, in particular, going to "the doctor" (General Practitioner or GP). These questions included: what they would like from a doctor; who in their family usually suggests that someone go to the doctor, what sorts of things are western doctors good for and not good for; whether they expect doctors to talk about their "whole" health; whether they usually understand what the doctor is doing; and what is the one biggest problem with going to the doctor? Concerning health, participants were asked: how they view good health; how they view poor health; who usually sees to it that family members are healthy; and who do they most confide in about health problems? Participants were also asked what they would do if there was a medical emergency, to whom a person should go and talk to if he or she had 'mental health' problems, and who, in their family, looks after those convalescing from an illness.

Results and Discussion

Perceptions of Good and Poor Health

Most of the participants rated themselves as in good health, with an average of 5.2 on the 7-point scale (slightly above the label "good"). Correspondingly, most were not concerned about their health, with an average of 2.5 on the scale of how concerned they were about their health. Both these ratings correlated with English proficiency, with better health and less concern about health both associated with better English.

Table 1 shows the frequency of the themes mentioned when asked about their views on good and poor health. The authors judged whether similar responses were the same theme and there was little disagreement about this. Participants' words were used in the Table rather than our re-wording of them. For example, "lack of sleep" was worded in just a few different ways but the responses were clearly meaning the theme as reported in Table 1-the full list of responses maps quite easily onto the responses listed. The themes have been put into five categories by the authors but other ways to organize these might be possible: health, moral/good clean living, mental life, getting things done, and family. The categories do not affect the results but are one way to order the themes.

Table 1 shows that many saw health in a positive way-as the presence of healthy attributes rather than the absence of sickness. There was also a strong association between being healthy, or not being in poor health, and mental health indicators such as being free from worries. Talking to themselves and thinking a lot were seen by some as problems of health. Many expressed that good health related to being able to do things and being active, and having a good enough standard of living to do things. Also of interest was the strong role that family played in health, with some viewing the absence of their families as a health problem (many family members are still in refugee camps overseas or missing, and refugees here have to pay airfares and application fees for reunification and this is difficult for many of them).

The question relating to how often they get out of the house for shopping, work or some activity provided interesting findings. While overall the average was high, 5.6 on the 7-point scale, there was a very strong gender difference in this sample, with men (M=6.76) going out of the house significantly more often than women (M=4.58), $F(1,52) = 24.0$, $p<0.001$. Going out of the house was also significantly positively correlated with English proficiency (Pearson $r= 0.45$, $p<0.001$). These results are worth following up as there are important health implications.

Family Organisation of Health

Some of the questions related to how families managed their health. When asked, "who usually suggests that someone needs to go to the doctor", and "who sees to it that family members are healthy", the answers were similar: primarily the parents (27 and 27 respectively) and the mother (17 and 20 respectively), with a few saying the father (3 and 5 respectively) or the male head of the house (1 and 1 respectively). Twelve participants also said that adults would look after themselves.

If there was an emergency, most (42) knew to go to an emergency clinic, 8 would phone an ambulance, 7 said they would go to their GP, 5 said they would dial 111, and one would recite the Qu'ran and pray to God. Some gave more than one answer in this section.

When asked whom they can most confide in about their health problems, the vast majority (44) said their GP, 6 said their spouse, 2 said a friend, and one each said their parents and God. Of interest was the response to the question "to whom should someone go if they had 'mental health' problems"? The largest number said the GP (24), with 20 saying mental health doctors or specialists, another 6 named psychologists or psychiatrists as a group, and 3 more said to go to the GP who would then refer the person on.

For convalescing after an illness, most said they would be looked after by their family (33), followed by nurses (12), their GP (6), the people living with them (5), parents

(2), and God (1). On the rating scales for seeking advice and talking about health problems with family or friends, the results were all near the low end of the scale and only slightly higher for family than for friends. On the 7-point scales the averages were: talking about a health problem with a family member (3.5), seeking advice from family member (3.2), seeking advice from a friend (2.7), and talking about a health problem with a friend (2.4). These questions put together suggest that participants rely heavily upon their GPs, even for getting advice in preference to family or friends. This supports our informal observations that people in this community do not discuss even minor illnesses amongs themselves but prefer to have such discussions with their doctors. This is important for health promotion, if word of mouth does not work in such a community.

GPs and Medical Service Provision

When asked what they would like from a doctor, most replied simply to be treated when sick, with a few others wanting a check-up, advice on health matters and medicine. On the questions about whether they expect doctors to talk about their "whole" health, the majority said yes (44), 9 said no, and one said yes "but doctors have so many constraints on their time that they cannot". Most encouragingly, when asked whether they usually understand what the doctor is doing, the majority said yes (42), 8 said no, and 4 said "not always". Interestingly, 10 of the 12 that said "no" or "not always" were female.

Table 2 shows what participants thought was good and bad about western doctors, categorized by the authors into areas of expertise, services and style. Many had no comment on these questions, and the interviewer reported that this was often for those new to the country. The majority who answered these questions saw western doctors as good because they have technologically advanced treatments.

Table 1. Themes and frequency of themes in response to questions about how the participants viewed good and poor health

Good Health	f	Poor Health	f
	HEALTH		
Being healthy	25	Being sick	37
Good food/eat properly	17	Not eating properly/unhealthy foods	18
No health problems/not being sick	13	Lack of sleep	10
Exercise/sports	10	Lack of exercise/inactive	7
Getting good sleep	5	Not getting treatment/medical care	5
Getting full medical care	2	Using drugs/smoking	4
To get medicine	2	Disability	2
No pain	2	Not controlling weight	1
Regular checkup	2	Slowing down to resistance is weakened	1
Keep away from dangerous things	1	Having sex with unhealthy person	1
Not being in accident	1	Not feeling good	1
Physically fit	1	Taking wrong medicine/ allergic	1
	MORAL / GOOD CLEAN LIVING		
Being happy, good morale	14	Not being clean/ unclean place/poor hygiene	12
Clean and healthy environment/ air free of pollution	15	Living in poor conditions	6
Good life style	1	Living in bad environment that makes sick	4
Clean water	1		
	MENTAL LIFE		
Having no worries, depression, stress	26	Having worries	31
Get a good education	3	Having problems in life/family problems	5
Have mental stability	3	Talking to yourself/Thinking a lot	4
Thinking positively	1	Being moody	2
		Lack of education	2
		Being mentally sick	1
		Living in a fearful environment	1
	GETTING THINGS DONE		
Good standard of living/ life/income	14	Not enough money to live on/poor standard of living	12
Getting your wants/needs in your daily life	7	Not being able to do things	5
Being able to do things without physical problems	4	Not getting your wants/needs in your daily life	4
Having employment	3	Unemployment	2
Being self-sufficient/ Take care of oneself	2	Not being self-sufficient	1
Having something to do	1		
	FAMILY		
Having friends	19	Not having family around you	4
Having family around you	6	Homesick	1
No family problems	1	Coming to new environment	1
To have a family (get marriage)	1		
Living in your own country	1		

There was, overall, a positive response to doctors, especially for not rushing them into treatments, for doing good check-ups, for explaining things first, and for a warm, caring and friendly manner. There were not many negative comments made about doctors, other than by a few individuals. The main problems were the long waiting lists and being slow to respond, and 5 women remarked that doctors (and midwives) rushed into things (such as caesareans) and "did not let the baby be born as slowly and naturally" as they wished.

With the open-ended question relating to the one biggest problem about going to the doctors, 20 said language, 11 said there were no real problems, 11 said medical costs, 7 said transportation, 2 specifically mentioned problems of translators, and one each said the long time it takes to see specialists and not knowing where to go in the hospital. When asked specifically whether or not in the last year they had not gone to the doctors because they could not pay, 26 said yes and 28 said no.

For the specific questions about barriers to accessing medical care, the greatest barriers were reported for payment of medical care, the doctor understanding them, availability of interpreters, satisfaction with communication, and their understanding the doctor. These five questions were the only ones in which more than ten participants made a rating of 3 on the 3-point scale. The main concerns, then, were about money, language, communication and understanding, including their understanding of the doctor. The four language-related questions were all rated higher for females than for males, and all four had negative correlations with English proficiency. These findings need further research to examine the contexts for the gender differences and English proficiency issues.

In both the open and specific questions, money or medical costs came up as a barrier. It turned out to be more difficult to identify exactly what the barrier was since many of the participants have community services cards for reduced medical charges, many go to a particular Hamilton doctor who often does not charge for his services, medical services for children are usually free, and specialist and hospital services are free. Even so, repeated visits for chronic conditions to a GP who does charge for services, some prescriptions, transportation, and childcare, can all be costs associated with health care. These need to be clearly separated out in future research rather than being posed as a unitary "monetary cost" barrier as was done here.

Conclusions

Overall, our sample from the Somali community in Hamilton reported themselves as being in good health with few special health problems. The main problems relate only indirectly to health, but are perhaps just as important for that reason and are therefore of specific concern to health and community psychologists. Most significant is the impact that lack of English proficiency has upon all aspects of utilising health services. The implication for health is that more effort should be put into teaching English, since weak English either requires funding for trained interpreters or puts stress on the already busy volunteer interpreters and family members, and decreases the effectiveness of most public health messages (Preciado & Henry, 1997). Most people interviewed, and our informal experience with the community, suggests they are keen to learn English but many did not have the time to learn properly and consistently and there are not enough English classes available that are

Table 2. Themes and frequency of themes in response to questions about what western doctors are good for, and what western doctors are not good for.

What western doctors are good for	f	What western doctors are not good for	f
Expertise		*Weak Expertise*	
Having technologically advanced medical treatments	15	Some doctors not good with tropical diseases/malaria	3
Good check-up	13	Sometimes say you are sick when not and vice versa	2
Good at operations	1	Not referring to specialist when needing one	1
Good advice	1	They drink alcohol and therefore lose judgment sometimes	1
		Not well qualified	1
		Do not understand our pregnancy; Do not wait long enough for baby to be born naturally	1
		Go on strike and people need help	1
Good Services		*Poor Services*	
Doing good tests first and not rushing	8	When you are very sick they act slow in responding to your needs/waiting list too long	8
Good service/ satisfying clients	4	Making hasty decisions, especially with pregnant women	4
Not rushing people to take medicine	2	High charges	1
Clean environment in clinics	1		
Being cheap compared to other doctors	1		
Friendly Style		*Unfriendly Style*	
Welcoming/friendly	7	Not relating to Somali cultural experiences	4
Helping clients as much as they can	5	Not helpful when lots of worries about family not here	1
Caring/ kind	4	Not responding to health problem	1
Having family doctor	2		
They ask for permission for tests or operations	1		
Listening to your problem	1		

both appropriate and affordable. Even as refugees, there are not specific English classes for them after their 6-week orientation period, but are rather informally organised through non-governmental organisations, voluntary groups or individuals.

Another important finding was the special reliance upon GPs to talk to and confide in about health problems, to visit for any "mental health" problems, and to act as family doctors treating more than presenting symptoms. There was an overall positive response to doctors, whom the community mostly saw as caring and friendly, with expertise in what they were doing. GPs who regularly treat refugees need to take note of these findings, since they show GPs to be key gatekeepers in refugee health. While it is good for the refugees to trust and consult GPs, a large number of instances consist of talking about issues or getting general health information and advice, rather than treating injuries or checking symptoms, and these public health information functions may not require a GP. In the long run, GPs might not have time for disseminating public health information and the refugee communities will need to begin thinking about other ways to handle this function. For example, training Somali nurses, public health contacts, or lay-health personnel may be a solution to these more widespread health concerns of people (DeSantis, 1997), and language would be less of a barrier to them.

This research also found some special issues for the Somali women. As reported above, their average proficiency in English was less than for the men and impacts on many facets of health. The Somali women also reported not getting out of the house as often as men and informal talks suggest that they link this to an increase in obesity (see Guerin et al., in press). There was also concern from some women that midwives and doctors rushed birthing and birthing interventions, and should not be so worried if the baby took longer to be born. The women also had main charge of looking after the health of the children despite their poorer English. All of these require more detailed research and interventions based upon the general findings here.

In conclusion, there are many aspects of public health provision that can facilitate services for Somali refugees. Providing some alternatives to relying on GPs for all health information would help in this regard, as would finding alternatives to the necessary use of interpreters for most contacts. Training Somali nurses or lay-health personnel would help both these problems. Finally, given that the majority of refugees are female, extra emphasis needs to be put on the provision of public health services for women in a way that makes them feel comfortable (Guerin et al., in press). All these research and intervention areas are ones that can involve applied psychologists, since the medical aspects are only a small part of the problems and the real issues are ones of language, social behaviour, and healthy practices.

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